WHAT IS CLAIMED IS:

1. A method for administering health care to patients within a patient population such that utilization of health care resources available to care for said patients within said patient population are conserved, the method comprising the steps:

a) generating said patient population, said generation of said patient population comprising the steps:

i) receiving a request from an individual to become a patient within said patient population;

ii) obtaining information from said individual in step (i);

iii) evaluating said data submitted in step (ii);

iv) enrolling said individual as a patient within said patient population; and

v) repeating steps (i) – (iv) for a multiplicity of individuals;

b) receiving a request from a patient within said patient population generated in step a) for medical services;

c) assessing said request made in step b) and determining whether said request substantiates a specified clinical event;

d) submitting a code corresponding to a single, specified medical service to be rendered in response to the clinical event specified in step (c);

e) evaluating the code submitted in step (d) for clinical and financial appropriateness; and

f) responding to said submission made in step (d) based upon said evaluation made in step (e), said response comprising either approval or disapproval of the services to be rendered in relation to said code submitted in step (d).

2. The method Claim 1 wherein in step (a), substep (ii), said information comprises demographic information related to said individual comprising the individual's age, sex, medical history and geographic vicinity pertaining to said individual's residence.

3. The method Claim 2 wherein in step (a), substep (iii), said evaluation comprises comparing said information submitted in step (a), substep (ii) with eligibility criteria, said eligibility criteria defining a standard by which said individuals are compared for acceptance as a patient within said patient population.

4. The method Claim 2 wherein in step (a), substep (iv), further comprises assigning a risk level to said patient.

5. The method Claim 4 wherein in step (a), substep (iv), said risk level assigned said patient is indicative of the anticipated utilization of resources said patient is projected to utilize while a member of said patient population.

6. The method Claim 3 wherein in step (a), substep (iii), further comprises assessing the current state of health of said individual and anticipated future health of said individual by retrospectively examining the individual's prior medical history and prospectively examining the anticipated future medical needs of said individual.

7. The method Claim 5 wherein following step (a), substep (v), such process further comprises step:

(vi) periodically updating and reviewing information indicative of the health of said patients within said patient population and reassigning risk levels associated with said patients within said patient population.

8. The method Claim 1 wherein in step (c), said assessment is made by a primary care physician.

9. The method Claim 8 wherein in step (d), said code represents a single, standardized medical service to be rendered in relation to a single, exclusive clinical event.

10. The method Claim 9 wherein in step (d), said code comprises a CPT code.

11. The method Claim 8 wherein in step (f) further comprises the step of determining whether to provide a reimbursement to said primary care physician for said services sought to be rendered in relation to said code submitted in step (c).

12. The method Claim 11 wherein in step (e), said evaluation of said code comprises reviewing said code submitted in step (d) to ensure against abusive billing practices.

13. The method Claim 11 wherein in step (e), said evaluation of said code comprises reviewing said code submitted in step (d) to determine the likelihood of a favorable clinical outcome of the service sought to be rendered in response to the clinical event.

14. The method Claim 1 wherein in step (f) said disapproval of said services sought to be rendered in relation to said code submitted in step (c) is followed by the further step:

(a) repeating step (b) – (d).

15. The method Claim 1 wherein in step (e), said evaluation is conducted by a hospitalist or case manager.

16. The method Claim 8 wherein in step (a) said primary care physician is a member of a network of physicians contracted to render medical services on behalf of a health plan, health maintenance organization, or government sponsored health care program.

17. The method Claim 5 wherein step (a) substep (iv) further comprises the step of charging a premium to said individual for becoming a member of said patient population.

18. The method Claim 17 wherein in said premium corresponds to said risk level assigned to said patient.

19. The method Claim 9 wherein in step (c), said code corresponds to a single medical service rendered exclusively by said physician.

20. A method for administering an integrated health care delivery system for providing comprehensive health care to a patients within a patient population such that utilization of health care resources available to care for said patients within said patient population are conserved, the method comprising the steps:

a) generating said patient population, said generation of said patient population comprising the steps:

i) receiving a request from an individual to become a patient within said patient population;

ii) obtaining information from said individual in step (i);

iii) evaluating said data submitted in step (ii);

iv) enrolling said individual as a patient within said patient population; and

v) repeating steps (i) – (iv) for a multiplicity of individuals;

b) receiving a request from a patient within said patient population for medical services;

c) assessing said requests made in step b) and determining whether said request substantiates the utilization of either in-patient services, out-patient services, referral to a specialist, or combinations thereof;

d) submitting a code corresponding to a single, specified medical service to be rendered in response to the utilization requested in step (c);

e) evaluating the code submitted in step (d) for clinical and financial appropriateness; and

f) responding to said submission made in step (d) based upon said evaluation made in step (e), said response comprising either approval or disapproval of the utilization requested as corresponding to said code submitted in step (c).

21. The method Claim 20 wherein in step (c), said assessment is made by a primary care physician.

22. The method Claim 21 wherein in step (d), said code represents a single, standardized medical service to be rendered in relation to a single, exclusive clinical event.

23. The method Claim 22 wherein in step (d), said code comprises a CPT code.

24. The method Claim 23 wherein in step (e), said evaluation of said code comprises reviewing said code submitted in step (d) to ensure against abusive billing practices.

25. The method Claim 24 wherein in step (e), said evaluation of said code comprises reviewing said code submitted in step (d) to determine the likelihood of a favorable clinical outcome of the service sought to be rendered in response to the clinical event.

26. The method Claim 24 wherein in step (f) said disapproval of said services sought to be rendered in relation to said code submitted in step (c) is followed by the further step:

(a) repeating step (b) – (d).

27. The method Claim 26 wherein in step (e), said evaluation is conducted by a hospitalist or case manager.

28. The method Claim 21 wherein in step (a) said primary care physician is a member of a network of physicians contracted to render medical services on behalf of a health plan, health maintenance organization, or government sponsored health care program.